

UNIVERSITY OF TENNESSEE, KNOXVILLE

FORM 1

EMPLOYEES (faculty and staff)

REQUEST FOR REASONABLE ACCOMMODATIONS

CONFIDENTIAL

This form is the initial step in an employee's request for accommodation at the workplace based on a disability. This will assist the University in determining whether, or to what extent, you are eligible for an accommodation in order to perform one or more of the essential functions of your job safely and effectively. Following your completion and submission of this form, the Office of Equity and Diversity will participate with you in a process that will involve interaction with you, your supervisor(s), and, if necessary, your health care providers. This process may also include health care professionals or subject-area specialists identified by the University as necessary to understand fully the nature of the disability, the accommodations requested and any accommodations suggested by the employee's health care providers.

<b>Employee Name:</b> JONATHAN BECKERS	<b>Work Telephone:</b> 974-3111
<b>Work Address:</b> 1101 CUMBERLAND AVE	<b>Preferred Telephone Contact Number:</b> 865-924-2825
<b>Job Title:</b> SECURITY OFFICER III	
<b>Department Head:</b> CHIEF TROY LAWE	<b>Office Telephone:</b> 974-3111
<b>Direct Supervisor:</b> LT JIM UNDERWOOD	<b>Office Telephone:</b> 974-3111
<b>The accommodation requested is:</b> DAY SHIFT ONLY MAX 40 hrs week - 8 hrs per shift NO OVERTIME	
<b>Are you currently receiving any accommodation to assist you with your job?</b> Yes No <input checked="" type="checkbox"/>	
<b>If "yes," have you submitted documentation to support this request to anyone?</b> Yes No	
<b>If "yes" to either question, please describe the accommodations and the location of the documentation:</b>	

I, JONATHAN BECKERS give the University of Tennessee permission to take steps necessary to explore whether I may be covered under reasonable accommodation definitions and standards under University policy and the Americans with Disabilities Act. This permission acknowledges that the office responsible for coordinating such employment requests, the Office of Equity and Diversity, may need to engage other appropriate University offices, including but not limited to: Human Resources, Health and Safety, Student Health, Facilities Management, Parking Services Student Disability Services, in the exploration of possible coverage or possible accommodations. I understand that all information and records obtained during this process will be maintained and handled in accordance with any applicable confidentiality requirements.

I further understand that I am required to complete and sign a "medical information request" form (Form 2) giving the University permission to consult with my health care professional(s) as necessary before the University can proceed with my request. Both forms must be turned in to the Office of Equity and Diversity, 1840 Melrose Avenue, Knoxville, TN 37996. Telephone: (865) 974-2498.

8/9

*Jonathan Beckers*  
Employee Signature

2-15-2021  
Date

University of Tennessee, Knoxville  
Employees (Faculty and Staff)  
Medical Information Request Form

FORM 2

**Introduction:**

University of Tennessee, Knoxville area employees requesting a reasonable accommodation at the workplace based on a disability must submit:

- The completed Request for Reasonable Accommodations form, filled out by the employee (Form 1); and
- this form, the Medical Information Request form, filled out by the employee's physician or health care provider (Form 2).
- Both completed forms must be returned to: ADA Coordinator, Office of Equity and Diversity, 1840 Melrose Ave., The University of Tennessee, Knoxville, TN 37996-3560.
- Forms may also be faxed to: (865) 974-0943
- For questions, please call (865) ~~974-0943~~

**Section 1: To be completed by employee**

JONATHAN BECKERS  
Employee Name

SECURITY OFFICER III  
Job Title

UTPD  
Department

LT JIM UNDERWOOD  
Supervisor

**Section 2: Release of Information (to be completed by employee)**

I give permission to my health care providers to release the following information to the University of Tennessee, Knoxville, to assist the University in determining whether, and to what extent, I may be eligible for a reasonable accommodation at the workplace.

I further give my health care providers permission to discuss my health conditions with the University of Tennessee, Knoxville, if necessary for clarification purposes.

Jonathan Beckers  
Employee Signature

2-15-21  
Date



provide him/her with a reasonable accommodation at the workplace based on a disability. A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. An employee making such a request must provide the University with current documentation of a disability. You are being asked by the employee to provide documentation by fully completing all sections of this form. These questions will help determine 1) whether the employee has a disability, 2) whether an accommodation is needed, and 3) what options may exist that would constitute an effective, reasonable accommodation.

The employee should provide you with a copy of his or her job description and functions. Please review the job description and functions, and any other information relative to the employee's work at the University in order to complete this form. The completed form may be returned to the employee, or may be mailed or faxed to the address listed in the introductory paragraph.

1. Please identify the employee's physical or mental impairment(s):

Brain MASS

2. Please describe the effects or limitations this impairment has on the employee's activities, if any:

Easy fatigue

3. Please describe whether the effects or limitations are long-term, permanent, or short-term.

Short term

4. Please review the information supplied by the employee concerning his or her job duties. What limitation(s) is interfering with the employee's job performance?

Work hours- Limited

5. Please describe what job functions the employee is having trouble performing because of the limitations:

None

6. How does the employee's limitation(s) interfere with his or her ability to perform the job?

*Limit hours*

7. Are there any activities or job duties that would present a health or safety risk to the employee or others due to the impairment or its treatment?

*NO*

8. Do you have any suggestions regarding possible accommodations to improve job performance?  
If so, what are they?

*- Day shift only -  
- Max 40 hours week -  
no overtime hours*

9. Any additional comments?

  
Signature of physician or care provider

*Passare/b m*  
Provider name (printed)

*501 20th St*  
Provider Address

*Ste 404*

*Knoxville, TN 37916*

*2-15-21*  
Date

*(865) 522-6964*  
Telephone #

Last updated 8/09